

Citation

Condition or Requirement

1932 (a)(4)  
42 CFR 438.50

**2. State process for enrollment by default.**

**Describe how the state's default enrollment process will preserve:**

**i. the existing provider-recipient relationship;**

After waiting the prescribed time to allow a recipient choice and prior to auto-assigning a recipient to a HMO, the State will review the recipient enrollment records through the past 12 months to determine whether the recipient has an existing provider-recipient relationship. If such a relationship is confirmed, the recipient will be auto-assigned to that provider.

**ii. the relationship with providers that have traditionally served Medicaid recipients;**

After waiting the prescribed time to allow a recipient choice and prior to auto-assigning a recipient to a HMO, the State will review the recipient enrollment records through the past 12 months to determine whether the recipient has an existing provider-recipient relationship. If such a relationship is confirmed, the recipient will be auto-assigned to that provider.

**iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702 (a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2).**

When maintaining provider-recipient relationships is not possible, the State will distribute recipients equitably among qualified MCOs based upon an algorithm developed by DHCFP. In order to serve the best interests of the State and program recipients, the algorithm will give weighted preference to any new HMO as well as HMOs with significantly lower enrollments, based on a formula developed by DHCFP.

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42 CFR 438.50**3. As part of the state's discussion on the default enrollment process, include the following items:****i. Indicate if the state will use a lock-in for managed care.**

An enrolled recipient may request disenrollment from the HMO without cause at any time. The enrollee is required to notify the DHCFP District Office of his/her decision to disenroll and, if he/she is a mandatory enrollee, he/she will be instructed to select another HMO or he/she will be auto-assigned to another HMO. A voluntary enrollee will be offered the option to join another HMO, if one is available, or return to the fee-for-service coverage plan.

**ii. Give the time frame for recipients to choose a health plan before being auto-assigned.**

A recipient is allowed up to 20 days from the mailing of the case decision notice to choose a health plan before being auto-assigned.

**iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment.**

Until such time as the MMIS system is able to assume this function, the State has delegated notification of choice options to the contracted HMOs. The State prior approves the written enrollment packet which the contracted HMOs use to provide this notification to potential enrollees. Potential enrollees are notified of their choice options through the written enrollment packet they are provided at the time they are determined eligible for HMO enrollment. They are also informed of the State's process for default or auto assignment in the event they fail to choose an HMO as well as their right to change HMOs at anytime during their enrollment. If the recipient does not choose an HMO within the prescribed time frame afforded to them, they are informed of their auto-assignment through a

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letter they are sent after assignment, which also informs them of their right to change HMOs, and by the information provided on their Medicaid Card commencing the month of coverage in which the assignment is effective.

**iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment.**

An enrolled recipient may request disenrollment from the HMO without cause at any time. The request to disenroll from the HMO is made to the Medicaid District Office. Medicaid recipients are notified of their right to disenroll from the HMO without cause at anytime by the written information in the enrollment packet they are provided at the time they are determined eligible for HMO enrollment.

**v. Describe the default assignment algorithm used for auto-assignment.**

To reduce large disparities and adverse risk between HMOs, the default assignment algorithm used by the State for auto-assignment is as follows and will commence when mandatory enrollment becomes effective in select areas of Washoe County and Clark County:

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<b>*Auto Assignment Algorithm</b>				
<b>Number of Plans in Geographic Service Area</b>	<b>Percentage of Recipients Assigned to Largest Plan</b>	<b>Percentage of Recipients Assigned to 2nd Largest Plan</b>	<b>Percentage of Recipients Assigned to 3rd Largest Plan</b>	<b>Percentage of Recipients Assigned to 4th Largest Plan</b>
<b>2 plans</b>	<b>34%</b>	<b>66%</b>		
<b>3 plans</b>	<b>17%</b>	<b>33%</b>	<b>50%</b>	
<b>4 plans</b>	<b>10%</b>	<b>10%</b>	<b>30%</b>	<b>50%</b>
<b>* The function of the algorithm is to ultimately achieve no less than a 10% differential in enrollment between all HMO contractors. Once the differential is achieved, use of this algorithm will be discontinued and head of households will be auto assigned on rotating basis.</b>				

The above algorithm will be implemented when mandatory managed care is established in both the North and the South. Until such implementation of the above algorithm, the auto assignment will occur on a 1:1 ratio in both the North and the South.

vi. **Describe how the state will monitor any changes in the rate of default assignment.**

The State will monitor the auto-assignment rates on a monthly basis through a generated MMIS system report effective upon MMIS full implementation.

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I. **State assurances on the enrollment process.**

1. **The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.**

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2. **The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52 (b)(3).**

\_\_\_\_\_ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52 (a) for MCOs and PCCMs. (If applicable, place check mark to indicate state's affirmation.)

3. **The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932 (a)(3) (C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)**

\_\_\_\_\_ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56 (g) if recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less. (If applicable, place check mark to indicate state's affirmation.)

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**J. Disenrollment**

1. **Affirm if the state uses lock-in for managed care and identify how many months (up to 12 months) will the lock-in apply.**

Nevada does not use lock-in for managed care.

2. **The state assures that recipient requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56 (c).**

An enrolled recipient may request disenrollment from the HMO without cause at any time.

3. **What are the additional circumstances of "cause" for disenrollment? (If any.)**

Not applicable (see #1, above).

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**K. Information requirements for beneficiaries.**1932 (a)(5)  
42 CFR 438.10  
42 CFR 438.50

The state assures that its state plan program is in compliance with 42 CFR 438.10 (i) for information requirements specific to MCOs and PCCM programs operated under section (a)(1)(A) (i) state plan amendments.

**L. Description of excluded services for each model (MCO & PCCM)**

The following services are either excluded as a HMO covered benefit or have coverage limitations.

**1. All services provided at Indian Health Service Facilities and Tribal Clinics:**

Native Americans may access and receive covered medically necessary services at Indian Health Service (IHS) facilities and Tribal Clinics. If a Native American voluntarily enrolls with a HMO and seeks covered services from IHS, the HMO should request and receive medical records regarding those covered services/treatments provided by IHS. If treatment is recommended by IHS and the enrollee seeks the recommended treatment through the HMO, the HMO must either provide the service or must document why the service is not medically necessary. The documentation may be reviewed by DHCFP or other reviewers. The HMO is required to coordinate all services with IHS. If a Native American recipient elects to disenroll from the HMO, the disenrollment will commence no later than the first day of the second administrative month and the services will then be reimbursed by FFS.

**2. Non-emergency transportation**

The DHCFP or its designee will authorize and arrange for all medically necessary non-emergency transportation. The HMO must verify medical appointments upon request by DHCFP or its designee.

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**3. All Nursing Facility stays over forty-five (45) days**

The HMO is required to cover the first 45 days of a nursing facility admission, pursuant to the Medicaid Services Manual (MSM). The HMO is also required to collect any patient liability (pursuant to 42 CFR 435.725) for each month a capitated payment is received, pursuant to the MSM. The HMO shall notify DHCFP by the fortieth (40<sup>th</sup>) day of any nursing facility stay admission expected to exceed forty-five (45) days. The enrollee will be disenrolled from the HMO and the stay will be covered by FFS commencing on the 46<sup>th</sup> day of the facility stay. DHCFP will retroactively adjust the capitation payment to cover only that portion of the month that the beneficiary is enrolled.

**4. Swing bed stays in acute hospitals over forty-five (45) days**

The HMO is required to cover the first forty-five (45) days of a swing bed admission pursuant to the MSM. The HMO is also required to collect any patient liability for each month a capitated payment is received, pursuant to the MSM. The HMO shall notify DHCFP by the fortieth (40<sup>th</sup>) day of any swing bed stay expected to exceed forty-five (45) days. The enrollee will be disenrolled from the HMO and the stay will be covered by FFS commencing on the forty-sixth (46<sup>th</sup>) day of the facility stay. DHCFP will retroactively adjust the capitation payment to cover only that portion of the month that the beneficiary is enrolled.

**5. School Based Child Health Services (SBCHS)**

DHCFP has an agreement with several school districts to provide selected medically necessary covered services through School Based Child Health Services (SBCHS) to eligible Title XIX Medicaid recipients.

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Eligible Medicaid enrollees, who are three (3) years of age and older, can be referred to a school based child health service for an evaluation by their private physician, school physician, special education teacher, school nurse, school counselor, parent or guardian, or social worker. If the child is found eligible for these services, then an Individual Education Plan (IEP) is developed for the child. The IEP specifies services needed for the child to meet educational goals. A copy of the IEP will be sent to the child's PCP within the managed health care plan, and maintained in the enrollee's medical record.

The school districts provide, through school district employees or contract personnel, the majority of specified medically necessary covered services. Medicaid reimburses the school districts for these services in accordance with the school district contract. The Vendors will provide covered medically necessary services beyond those available through the school districts, or document why the services are not medically necessary. The documentation may be reviewed by DHCFP or its designees. Title XIX Medicaid eligible children are not limited to receiving health services through the school districts. Services may be obtained through the Vendor rather than the school district, if requested by the parent/legal guardian. The Vendor case manager shall coordinate with the school district in obtaining any services which are not covered by the plan or the school district.

#### **6. Intermediate Care Facility for the Mentally Retarded (ICF/MR)**

Residents of ICF/MR facilities are not eligible for enrollment with the HMO. If a recipient is admitted to an ICF/MR after HMO enrollment, the recipient will be disenrolled from the HMO and the admission, bed day rate, and ancillary services will be reimbursed through FFS. DHCFP will retroactively adjust the capitation payment to cover only that portion of the month that the beneficiary is enrolled.

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**7. Residential Treatment Center (RTC)**

Medicaid enrollees will be disenrolled from the HMO in the month following the RTC admission. The RTC admission, bed day rate, and ancillary services will be reimbursed through FFS thereafter for Title XIX Medicaid Recipients.

**8. Hospice**

Recipients who are receiving Hospice Services are not eligible for enrollment with the HMO. If a recipient is made eligible for Hospice Services after HMO enrollment, the recipient will be disenrolled from the HMO and the Hospice Services will be reimbursed through FFS. DHCFP will retroactively adjust the capitation payment to cover only that portion of the month that the beneficiary is enrolled.

**9. Institutions for Mental Diseases (IMDs) for Title XIX eligible recipients ages twenty two (22) through sixty five (65) years of age**

Federal regulations stipulate that Title XIX can only reimburse for services to IMD/psychiatric hospital patients who are 65 years of age or older or under the age of 21 years. Residents of IMD facilities who are 21 years of age to 65 years of age are not eligible for enrollment with the HMO. If a recipient is admitted to an IMD after HMO enrollment, the recipient will be disenrolled. DHCFP will retroactively adjust the capitation payment to cover only that portion of the month that the beneficiary is enrolled.

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**10. Adult Day Health Care**

Recipients who are receiving Adult Day Health Care (Provider Type 39) services are not eligible for enrollment with the HMO. If a recipient is made eligible for Adult Day Health Care after HMO enrollment, the recipient will be disenrolled and the Adult Day Health Care will be reimbursed through FFS. DHCFP will retroactively adjust the capitation payment to cover only that portion of the month that the beneficiary is enrolled.

**11. Home and Community Based Waiver (HCBW) Services**

Recipients who are receiving HCBW Services are not eligible for enrollment with the HMO. If a recipient is made eligible for HCBW Services after HMO enrollment, the recipient will be disenrolled and the HCBW Services will be reimbursed through FFS. DHCFP will retroactively adjust the capitation payment to cover only that portion of the month that the beneficiary is enrolled.

**12. Pre-Admission Screening and Resident Review (PASRR) and Level of Care (LOC) Assessments**

A PASRR and LOC are reimbursed by FFS. Conducting a PASRR and LOC will not prompt HMO disenrollment. However, if the recipient is admitted into a nursing facility as the result of a PASRR and LOC, the HMO is responsible for the first 45 days of admission for the recipient (see 3., above).

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